

 F0R OFFICE USE ONLY

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| DATE RECEIVED: ENTER DATE | DATE SENT: ENTER DATE |  DATE RECEIVED: ENTER DATE | DATE ALLOCATED:ENTER DATE |

 **Respite Referral Form**

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| General Outreach Support (£) |[ ]  Self-reliance & Confidence (£) |[ ]  Participate in Sports (£) | [ ]  |
| Social Community Engagement (£) |[ ]  Back to College or Work (£) |[ ]  Coping Strategies (£) |[ ]
| College Enrolment/Joining a Club (£) |[ ]  Accessing Community Resources (£) |[ ]  Emotional Regulation (£) |[ ]
| Daily Independent Living Tasks (£) |[ ]  Developing Life Skills (£) |  | English Tutoring (£) |[ ]
| Other, please specify |  |

 (£) denotes a costed service – please confirm funding prior to referral.

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| **Individual** |
| Surname |  | Forenames |  |
| Gender |  | Date of Birth |  | Year group |  | % Attendance |  |

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| **Who is referring?** |
| Parent/Guardian | Contact Name | Position |
|  |  |  |
| Contact Number | Email Address | Date |
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| **What is the main reason for the referral?** |  |

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| What are the desired outcomes? |  |
| Strengths: |  |

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| **Individual’s details** |
| Primary address | Secondary address |
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| Postcode:  |  | Postcode:  |  |

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| **Does the individual receive…?** |

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| Free school meals? |[ ]  Pupil premium? |[ ]  1:1 support? |[ ]  ENF? (yes/no) |[ ]  If yes, start date. |  |
| Is this a Child Looked After? |[ ]  CP/CIN |[ ]  EHCP? (Yes/No In progress)  | [ ]  | EHM/TAF? |[ ]
| Previous Lighthouse Outreach Service intervention? |
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| **Parent/carer details** |
| Full name: | Address:(if different from the young person) | DOB | Gender | Parental responsibility | First language: |
|  |  |  |  |  |  |
| Contact Number 1 | Contact number 2 | Email |
|  |  |  |
| Full name: | Address:(if different from the young person) | DOB | Gender | Parental responsibility | First language: |
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| Contact Number 1 | Contact number 2 | Email |
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| **Family composition/significant others** |
| Full name  | Address, Postcode, and Tel  | DOB if known  | Relationship to individual named overleaf  |
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| **Who is working with the individual/family?** |
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|  | Y/N | Active (Y/N) | Worker / Contact Details |
| CAMHS |  |  |  |
| Education Psychologist |  |  |  |
| Social Worker |  |  |  |
| Intensive Families First |  |  |  |
| Family Support Worker |  |  |  |
| Attendance Officer |  |  |  |
| Other Professional Agency |  |  |  |
| Other (please specify)  |  |  |  |

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| **Please complete this section if an EHM has been completed** |
| On this individual (Y/N) |  | Date: |  |
| On another young person in the Family/Household (Y/N)  |  | Date: |  |
| Is the EHM active? (Yes/No)  |  |
| Name of Lead Professional: |       | Email: |  |

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| **Academic history** |
| College | From | To | Reason for move |
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| Personal Support Plan  | DETAILS:  |
| Risk Management Plan | DETAILS:  |

 **Additional information (if required).**

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| **Data Privacy & Information Sharing Statement** I confirm that following discussion with college/setting/parent/caregiver, I agree to the involvement of Lighthouse Outreach Service. I have had the reasons for this service request explained to me, I understand the reasons for the request and understand that my information will be shared with Lighthouse Outreach Service as part of this request. I agreed to the request and give consent for Lighthouse Outreach Service to work with my child (or me as the named individual). **I understand that by requesting assistance from Lighthouse Outreach Service, this does not in any way guarantee a placement at a provision. All requests for specialist placements will be in line with the SEND Code of Practice.** I understand that working with my child (or me) will necessitate the sharing of information between relevant services, in the interests of providing a service to me or my child. I understand that the information contained within this form will be recorded on a computer system. Lighthouse Outreach Service is the Data Controller of this information and its lawful basis for processing is to fulfil its duties in respect of social emotional and mental health or special educational needs provision (public task). Please indicate in the ‘**Additional Information’** section the relevant services **you do not wish** information to be shared with, however, please note there may be circumstances where we have to share your details without your consent, eg if we believe it is in the best interests of the individual. |

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| **Permissions** |
| Relationship to individual  | Signature: | Date: | Comments |
|  |  |  |  |
| Individual’s Name: | Signature: | Date: | Comments |
|  |  |  |  |

 Please return to Referrals7@outlook.com

  **Trevor Adams**

 **Behaviour Practitioner Lead**

 **Mindfulness Teacher**